HOSPITALS AND AMBULATORY JCAHO SURVEY RESULTS FOR CY 2002

HOSPITALS CY-2002
SUMMARY OF JCAHO TYPE ONE FINDINGS:

ASSESSMENT OF PATIENTS

Initial Assessment:

PE.1.8 – At one MTF, one of 16 open and closed medical records for patients undergoing operations or other procedures included a medical history and physical examination that was more than 30 days old and had no documentation of a current update and review. Medical staff documents required that any preoperative history and physical more than 7 days old be updated, and that any older than 30 days be repeated prior to performing a procedure. The deficient record was for a patient undergoing GI endoscopy with IV sedation.

PE.1.8.1 – At one MTF, one of 16 open and closed medical records reviewed for patients undergoing sedation or anesthesia lacked documentation of a pre-anesthesia assessment. The deficient record was for a patient undergoing GI endoscopy with IV sedation.

PE.1.8.2 – At one MTF, 4 of 21 open and closed medical records for patients undergoing procedures with anesthesia or sedation lacked documentation that a licensed independent practitioner with appropriate privileges had determined the patient to be an appropriate candidate for the planned anesthesia using ASA classification or some similar method of stratifying risk (81% compliance). All of the records lacking the expected documentation were for patients having procedures with IV sedation. In addition, at another MTF, one of 16 open and closed medical records for patients undergoing operative or other procedures lacked documentation of a determination that the patient was and appropriate candidate for anesthesia before induction. The record lacking appropriate documentation was for a patient undergoing GI endoscopy with IV sedation.

Pathology and Clinical Laboratory Services – Waived Testing:

PE.1.15.2 – At one MTF, the state of the quality control logs in the emergency department was poor. The quality control logs for the urine dipstick testing and for the pregnancy testing did not have the proper lot numbers recorded. Also, the log sheet for the Hemocue machine indicated the month of January (when it was actually February) and the mistake had been perpetuated since December. The lot numbers also did not correlate with the reagent being used in the machine and the fecal occult blood testing kits had no logs maintained on them at all.

CARE OF PATIENTS

Planning and Providing Care:

TX.1.2 – In review of open and closed medical/surgical records at one MTF, it was noted that the care plans consistently lacked identification of all of the patients' problems needing to be addressed. It was further noted that there was not consistent collaboration/coordination among the various disciplines in identifying and prioritizing patient care needs.

Behavioral patient care plans were in the format of a protocol and were generic in nature, not identifying patient-specific problems needing to be prioritized and addressed by the treatment team in a collaborative manner.

In the chemical dependency program, care plans for those individuals placed on Antabuse did not incorporate this intervention. In behavioral health inpatient, the plan of care was a clinical pathway, but individual patient care needs were not incorporated.

LEADERSHIP

Role in Improving Performance:

LD.5 – At one MTF, there was no evidence of a report to the governing body on the occurrence of medical/healthcare errors and actions taken to improve patient safety, both in response to actual occurrences and proactively within the last 12 months.
LD.5.2 – At one MTF, the organization demonstrated a failure mode and effects analysis. However, there had been no formal root cause analysis on the highest criticality points.

MANAGEMENT OF HUMAN RESOURCES

Assessing Competence:

HR.5 – At one MTF, an annual staff competency report to the Governing body for a particular year documented that 97% of the performance evaluations were completed in a timely manner pursuant to the organizations established frequency. This gave insufficient evidence of acceptable compliance to this standard. Secondly, 2 out of 17 personnel records reviewed of non-credentialed staff providing patient care lacked a performance assessment addressing the ages of the patients served.
Also, another MTF reported 90.3% compliance with its' performance evaluations as well.

MANAGEMENT OF INFORMATION

Patient-Specific Data and Information:

IM.7.3.2 – regulation AR 40-66-7c.SF 516 allows dictated operative reports to be completed immediately but no later than 24 hours following surgery. Aggregate data presented by one organization indicated that 69 percent of the operative reports dictated within the past 12 months were dictated the day of surgery.
IM.7.10 – In another MTF, data related to record review was collected in only three of the last four quarters regarding donation, and receipt of transplants and or implants. Data related to record review was collected in only two of the past four quarters related to autopsy results.
A concurrent review of the history and physicals being performed by residents should commence. The lack of pertinence and brevity of the physical examination portion of the history and physical was found to be less than pertinent to the patients condition in at least two of the open medical records reviewed.
The state of emergency room records is poor. The quality of the organization of the documentation in this area needs to be improved. Of 6 records reviewed for medical care in the emergency room, 5 were found to be deficient in some way with regard to accuracy or organization.
The collection of data regarding patient preferences for learning, readiness to learn and barriers to learning vary among the ambulatory clinics visited. If the documentation in the clinic is computerized the intent of this standard is being met, however, in those clinics that are not yet computerized the gathering of this information is inconsistent.
The process for screening patients in the OB/GYN clinic for nutritional needs was less objective than the screening occurring in other ambulatory clinics. There were no established criteria specific to the clinic for referring a patient for an assessment based on the physician preference. However, in the clinics where documentation was computerized, screening criteria was being utilized to make a referral to the dietitian.
In addition, medical students are documenting on the main ER record. There is little evidence of clinically pertinent co-documentation by privileged provider. The co-documentation by privileges providers was insufficient.
There was one undesirable outcome in the past, where medical student documentation was identified as one of the root causes. However, at survey, medical students were still completing documentation in this area.

MEDICAL STAFF

Organization, Bylaws, Rules, and Regulations:

MS.2.6 – At one MTF, the medical staff process to identify and manage matters of practitioner health and impairment, described in their policy, lacked two of the seven expected design elements bulleted in this standards intent: (1) Self-referral by the practitioner and (2) Maintenance of the confidentiality of

the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened. (71% compliance) A draft version of a revised process, not approved and implemented at the time of the survey, did include all seven expected design elements.
Credentialing:
MS.5.5.1 – The bylaws and Army Regulations do not mention the fact that physicians will be required to disclose voluntary relinquishment of DEA and state narcotics registration. Also the regulations and bylaws do not mention that a physician must disclose current pending challenges to license or registration.
The applications are compliant and this information is obtained, but the medical staff documents are silent on the above issues.

HOSPITALS-BEHAVIORAL-(EDIS)-2002
SUMMARY OF JCAHO TYPE ONE FINDINGS

ASSESSMENT
Initial Screening and Clinical Assessments:
PE.1.3 – At one MTF, in only one out of five records reviewed, was there a screen for nutritional risk. A new process has been identified but it was not present in the records reviewed.
PE.1.8 – At two MTFs, pain was only assessed in one out of five records reviewed in the EDIS program.
Additional Requirements for Specific Patient Populations:
PE.1.18.1 – At one MTF, because of the nature of the EDIS program, the records did not consistently document an analysis of the potential impact of the child's problems on the family, and of the potential impact of the family dynamics on the family participation in the day- to-day implementation of the IFSP.

CARE
Treatment Planning:
TX.1.4.1 – In the EDIS program at one MTF, there was no process in place which helps in identifying and prioritizing the patient care needs of the individual and justifying when needs are differed.
In addition, at another MTF, although needs were identified in about half of the records reviewed, there was no justification for deferring treatment when those needs were not placed in the IEP or IFSP.
TX.1.5 – At one MTF, treatment goals were very general and not measurable in records reviewed in the EDIS (Educational and Intervention Services) program.

HOSPITALS-2002
SUMMARY OF JCAHO SUPPLEMENTAL FINDINGS:

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS
Patient Rights:
RI.1.2 – At one MTF, in the Addictions Program, families are appropriately involved in treatment when clinically indicated; however, the services are provided through referrals to other programs due to lack of staff available to provide family services. To enhance continuity of care, the surveyor recommends considering expansion of staff available to provide family treatment within the Addictions Program.
RI.1.2.1 – At one MTF, the hospital consent form is generic and is used for both minor and major procedures. In some of the reviewed closed and open medical records, the information in the consent

form was not individualized and did not address the patient specific condition, nor the expected benefits or the risks associated with the proposed treatment.

ASSESSMENT OF PATIENTS

Initial Assessment:

PE.1.4 – At one MTF, the MEDCEN Memo 40-31 did not require pain to be assessed in all patients. Instead, it stated: "Pain level is assessed in all patients as clinically indicated"… Further, paragraph #5 Procedures, of the same memo, stated that the Outpatient assessment & reassessment process required…Pain is assessed as clinically indicated. Finally, 2 out of 2 Outpatient Dermatology, 2 out of 2 Outpatient ENT, 1 out of 2 Outpatient Occupational Therapy, 2 out of 2 Physical Therapy Outpatient, and 1 out of 1 Speech Outpatient records lacked documentation that the presence of pain was assessed. It should be noted that all 3 of the Outpatient Internal medicine records contained a pain assessment.

PE.1.8 – At one MTF, one of 21 open and closed medical records lacked an updated history and physical prior to a surgical procedure. One H & P was done on March 19, 2002 with the procedure being done on April 17, 2002.

Pathology and Clinical Laboratory Services – Waived Testing:

PE.1.15 – During the tour of the OB/GYN Clinic at one MTF, the use of pH paper was noted. There was no expiration date on the container, nor was there any process for conducting quality control on the paper.

Care Decisions:

PE.3 – At four MTFs, in the review of open and closed medical records, it was noted that the nursing assessments consistently lacked full identification of the patients' problems for inclusion into the care plan. It was further noted that there was not consistent collaboration/coordination among the various disciplines in identifying and prioritizing patient care needs for inclusion in the plan of care.

CARE OF PATIENTS

Planning and Providing Care:

TX.1.2 – At two MTFs, it was noted that the patient care plans did not consistently address all of the patient problems/needs identified by various clinical disciplines in their assessments. This was confirmed through open record review and interviews with staff.

Also, at just one of the mentioned MTFs, care planning documented in open medical records reviewed was multidisciplinary, but it was often not recorded in a manner suggesting that it was interdisciplinary and collaborative. Each clinical discipline usually documented their own care planning elements in their own separate notes. The interdisciplinary, care Planning Tool, in the records, was used almost exclusively by nursing staff members.

Anesthesia Care:

TX.2.2 – At one MTF, one of 13 open and closed medical records for patients undergoing procedures with IV sedation lacked both signed consent for sedation and any documented discussion of the risks and options associated with sedation.

In addition, at another MTF, one of ten open and closed medical records for patients undergoing anesthesia or sedation lacked documentation of discussion of anesthesia risks and options with the patient prior to administration. (90% compliance) The record lacking such documentation was for a patient who received IV sedation for GI endoscopy.

Medication Use:

TX.3.3 – At one MTF, many wide range orders were seen for PRN pain medications. Doses varied greatly, as well as route and time frames. The time frames were not backed up by any protocol for administration and nurses were left to decide without guidance. Additionally, orders were written that allowed the nurse to even choose the route of administration.

Nurses were also presented with 3 choices of antiemetics, in one record reviewed, without any supporting protocol as o which medication to select.

At another MTF, a review of a DA Form 3949 for Radiology, documented that 23 out of 89 documentations of controlled substance administrations lacked the required signatures (only initials were provided & in one case no authentication was documented).
Also, the plastic surgery clinic was admixing epinephrine solution with local anesthetic. Such practice was questioned since the organization had the appropriate solutions of local anesthetic with the appropriate concentration of epinephrine.
Also, at one other MTF, one of 16 open and closed medical records for patients undergoing operations or other procedures lacked evidence of appropriate implementation of medication use policies and procedures. The deficient record was for a patient undergoing GI endoscopy with IV sedation. Medications recorded as being administered, including narcotics, were not supported by an underlying physician order, an expectation created by the facility's sedation policy.
TX.3.5.3 – At one MTF, during the Pharmacy visit, it was noted that the medication locker servicing off-hours when the Pharmacy was not open contained a very large range of stock. Additionally, although the organization had order entry and used it for medications ordered by physicians in the ambulatory setting, this was not the case for inpatient orders written off-hours. In-patients were not afforded the same safety feature because of computer related difficulties. This practice did not afford all patients the same safety practices aimed at reducing the risk of errors.
TX.3.5.5 – At one MTF, the emergency contrast reaction kits are locked and maintained by the Radiology department. However, there is no way to tell if the medication has been removed as opposed to restocked. The checks of these medications did not match that of the crash cart. Also, the same situation existed in the Pediatric Clinic. Emergency response medications were in a cabinet and not properly secured against tampering as described above.
Also, on the OB unit at another MTF, medication tackle boxes were present to be used in the event of a newborn emergency. There was no process to verify the integrity of the locks on these boxes as there was on the emergency crash cart. The documentation about verification of the integrity could be consolidated onto the present crash cart log rather than instituting another form.
Nutrition Care:
TX.4 – At one MTF, patients are screened for nutrition risk as part of the nursing admission assessment. The criteria that is being used to screen patients within 24 hours of admission is basically different than that of the criteria used by dietitians who do not screen within the first 24 hours. The best example is the omission of lactating patients/geriatric surgical patients on the nursing screening criteria, yet is utilized by the dietitians sometime after the first 24 hours of admission.
Geriatric surgical patients were not included within the organization's criteria for patients at nutritional risk.
Operative and Other Procedures:
TX.5.3 – At one MTF, plans for perioperative nursing care were documented in only 14 of 21 open and closed medical records for patients undergoing operations or other procedures (67% compliance). The deficiencies were in records for patients receiving IV sedation.
Also, one closed record for a patient undergoing cardiac catheterization with local anesthesia, lacked the documentation that the nursing care given during the procedure, had been supervised by a registered nurse.
TX.5.4 – At one MTF, in one of five moderate sedation medical records reviewed, it was noted that a patient who had a shoulder reduction in the Emergency Department was monitored post-procedure only for one 15 minute interval rather than for four periods as required by hospital policy.
Rehabilitation Care and Services
TX.6.3 – At one MTF, 3 out of 4 Physical Medicine Outpatient records reviewed, lacked documentation of the patient's goal for therapy.
At another MTF, in three open medical records, rehabilitation care planning for the physical therapy (PT) section lacked documentation of incorporating the patients' personal goals for rehabilitation into the care planning process. Subsequent brief review of several closed records for PT patients demonstrated that such documentation was usually included.

Also, at yet another MTF, the physical rehabilitation plan incorporates the patient's personal goals for rehabilitation. The reviewed rehab records did not clearly document the patient's personal goals.

Special Procedures:

TX.7.1.7 – At one MTF, the closed medical records of patients who were in restraint did not consistently reflect complete orders describing the amount of time the order for restrain was valid.

TX.7.1.8 – The organizational policy for when patients are in restraints requires there to be an in person evaluation by a licensed independent practitioner each time a restraint order is written/renewed (every 4 hours). The closed medical records of patients who were restrained on the psychiatric unit did not consistently provide evidence of the inpatient reevaluation of a patient at least every 4 hours while the patient was in restraint.

TX.7.5 – At one MTF, although appropriate data was being collected addressing the use of medical restraints, there was insufficient analysis to include how the restraint use could be reduced e.g. developing strategies to lessen the length of time in restraints beyond 24 hours.

TX.7.5.4 – At one MTF, during the Closed Medical Record Review, it was noted that three episodes of restraint in two patient records lacked consistent nursing documentation indicating the patient had been checked with the timeliness required in the organization's policy.

EDUCATION

Patient and Family Education and Responsibilities:

PF.1 – At one MTF, in the review of open and closed caesarian section records, it was noted that the documentation of the education given to section patients did not address the specific needs of these post-surgical patients.

PF.2 – At one MTF, it was noted that documentation of the education process was not interdisciplinary or consistently coordinated among various clinical disciplines. This was confirmed during interviews with staff and the review of open and closed medical records.

Open medical records reviewed demonstrated multidisciplinary patient education, but documentation of it did not suggest interdisciplinary coordination. The interdisciplinary, documentation tool, included in the records, was used only by members of the nursing staff.

IMPROVING ORGANIZATION PERFORMANCE

Data Collection:

PI.3.1 – One organization has not yet implemented measurements to assess patients' perception of safety. However, the organization has implemented a voluntary reporting system for patients who have safety concerns.

PI.3.1.1 – One organization has not yet undertaken measurement to assess the effectiveness of its pain management program. Patient satisfaction has been measured.

Aggregation and Analysis:

PI.4 – At one MTF, data about resuscitation and restraint is being collected. However, evidence of analysis of the information to make improvements in care is not documented. Specific reference is made to the lack of analysis of variances that are identified regarding medication errors in the Pharmacy, analysis of ways to improve survivability for resuscitation, and the reduction of reasons for restraint in the acute care population.

At another MTF, it was noted that although appropriate data points were being collected and presented, the intense analysis process was not detailed enough to really understand the scope and results of the analysis. References to opportunities for improvement were not clearly identified. In some instances there was no trending over time, little use of thresholds as desired performance indicators or use of control charts.

PI.4.3 – At one MTF, dispensing errors in pharmacy were reported as being high. Near misses contributed to a large amount of these errors. It became evident that patients were going home with the wrong medication when dispensed to outpatients. There was little evidence that the organization had instituted significant improvements in this process.

Blood culture contamination rates have been measured for a long time. It was identified that staff turnover resulted in higher contamination rates. However, no results have come from improving the training and education of new staff.

LEADERSHIP

Planning:

LD.1.3.2 – At one MTF, open and closed behavioral health records reviewed lacked documentation of patient specific problems in connection with care planning.

LD.1.6 – At one MTF, a record of a child who had received Ketamine sedation in the emergency room was reviewed. This record did not contain proper assessments documented as required by the hospital moderate sedation policy. Forms to record assessments and vital signs were not consistent with other practice in the hospital.

Directing Departments:

LD.2.5 – At one MTF, in the review of personnel files, it was noted that although performance evaluations by managers included age-specific criteria, there was use of all performance indicators to measure age-specific competencies when in fact many were not related to the job requirements.

Integrating and Coordinating Services:

LD.3.4 – At one MTF, a single, well-planned policy guiding use of IV sedation had been applied to the entire facility. The four principal sedating locations – emergency services, gastroenterology, cardiology, and radiology, had developed differing procedures and different tools for documenting implementation of the policy. The result was that documentation in some areas was more complete that in others. A more common practice, which does contribute to achieving the same level of care in all anesthetizing locations, is to have a single tool for documenting patient care involving IV sedation. The common denominator for all of these patients is IV sedation. The common tool related to documenting sedation care could then be supplemented by unit specific documentation needs, either on the same piece of paper or another one. The time honored role model is preoperative and anesthesia documentation for procedures performed in an operating room. Some of the documentation for patients receiving sedation can be abbreviated, but the basic expectations are the same.

MANAGEMENT OF ENVIRONMENT OF CARE

Planning:

EC.A.2L.2 – At one MTF, the door on the Dental lab, a room with active natural gas jets and electrical equipment, did not have an automatic closing mechanism on the door.

EC.A.3C.2 – At one MTF, a horizontal penetration was noted within the smoke partition at the entrance to the inpatient Psychiatric Unit.

EC.A.3D.1 – At one MTF, the Reproductive Unit corridor double doors and the Radiology to main corridor & Lab to main corridor doors had in excess of one eighth inch median gap. Also, another corridor door had in excess of ¾ inch undercut.

EC.A.51 – At one MTF, during the Building Tour, it was noted that the non-conforming route of egress in the central stairwell to the seventh floor roof exit was not appropriately signed to indicate that it was not an approved exit route. This was corrected prior to surveyor departure.

At another MTF, the door leading to the enclosed courtyard (no other exit) from the family lounge on the Pediatric Unit did not have a Not an Exit sign. This was corrected immediately.

EC.1.4 – A site-specific hazard vulnerability analysis had not been completed for several clinics. In addition, response procedures were not developed for highly probable risks, which then should be drilled at least annually.

EC.1.5.1 – At three MTFs, although their Plans For Improvement (PFI) were determined to be acceptable, additional Life Safety Code (LSC) findings had also been identified. Part 4 – PFI of the Statement of Conditions (SOC) must be immediately updated to include all supplemental recommendations identified in your official report. The updated PFI does not need to be sent to the

Joint commission; however, it remains the MTFs responsibility to continue to maintain and update the PFI for review at future surveys

Implementation:

EC.2.1 – The garbage compactor on the loading dock, at one MTF, was continuously maintained in the energized operational mode while unsupervised thus potentially allowing for unauthorized operation & becoming an attractive nuisance issue.

Secondly, several potential patient suicide risks were noted within the Inpatient Psychiatric unit, namely: 1) patient shower heads, wash cloth/soap dishes, and water mixing valves protruded from the wall in a fashion that could serve as an anchoring point for a potential suicide device, 2) patient toilets had plumbing at a height that could serve as a potential suicide anchoring point & contained a bed pan flusher arm, 3) patient toilet room door handles were of the conventional knob type that could be used to abet a potential suicide attempt, & 4) ceiling & wall exhaust grills within the patient bathrooms & patient rooms had exposed horizontal fins that could be used to secure a potential suicide device.

At another MTF, the following safety hazards/deficiencies were noted: 1) several cigarette butts were noted o the hospital roof, 2) the emergency stairwell door leading into Pediatrics was locked, however, no "Door Locked - No Re-entry" signage was posted on the stairwell side of the door, 3) the emergency stairwell floor level designation signage did not indicate the distance to the point of discharge as required by NFPA 101-5.2.2.5.4 & .5, 4) several potential patient suicide issues were noted within the inpatient psychiatric unit, viz. :a)patient shower heads horizontally protruded from the shower wall and would permit the securing of a patient suicide device, b) patient shower water mixing valves, open grab bars, and soap/washcloth holders provided a potential anchoring point for a patient suicide device, c) metal shower curtain hooks were present in patient showers that could serve as mutilation devices, d) non-tamperproof screws were present in the shower water mixing valves, e) portable fire extinguishers housed within wall recessed cabinets with in the patient area were accessible to patients for unauthorized use/access, 5) an unsecured acetylene cylinder was noted within the ground floor main mechanical room (this item was corrected during the survey), and 6) the double corridor doors leading into the Clinical engineering department had in excess of 1/8 inch median gap – this was corrected during the survey.

The organization was aware of risk reduction strategies related to the presence of metal oxygen cylinders in the MRI suites from experience in the national literature. However, at survey, metal oxygen cylinders, and a metal crash cart were close to the MRI magnet room. This was corrected at the time of survey and the metal cylinders were replaced with aluminum and the crash cart was tethered to the wall to prevent a mishap in time of panic.

EC.2.2 – At one MTF, the off-shift visit concentrated on security within and around the medical center premises. The hospital security NCO discussed the current Installation security posture and the current use of a Department of the Army civilian police force, an Army National Guard augmentation Military Police unit, and augmentation soldiers from the hospital to man the gates

Although it is recognized that one of a soldier's core competencies is the ability to pull perimeter security duties, as a long-term resource for Installation security, with potential constrained hospital personnel resources, it is not felt to be beneficial to medical staffing requirements. It is a recommendation that the Installation be resourced to support a larger police force thus eliminating the need for hospital staff augmentation. Further, recommend that the Installation consider providing a more pronounced law enforcement presence in the Medical Center to readily respond to and deter potential incidences.

EC.2.3 – During the tour of the OB unit at one MTF, large amounts of Formalin were being decanted to preserve placentas. Respiratory masks/eye shields need to be used when pouring large amounts of formalin.

At another MTF, in the Imaging Department hot lab, the leaded door of an under the counter cabinet did not close properly; higher radiation was detected from the contents of this cabinet. This issue was addressed during the survey.

EC.2.7 – At one MTF, during the E.C. Document Review, it was noted that five of the twelve months of test results for each of two generators did not meet 30% of face plate requirement. This problem was identified around the fifth month and corrections instituted. The remaining seven months of testing results met the required 200 kW requirements.
EC.2.10.2 – At one MTF, at the time of survey, the total number and location of all fire and smoke dampers was unclear. The hospital is actively engaged in the process of locating and properly testing all dampers.
Measuring Outcomes Of Implementation:
EC.4.2 – At one MTF, a review of the safety committee meeting minutes for a period of 12 months documented that the committee, consisting of 22 members, met eleven times. During those eleven meetings, five members were absent for five or more meetings thus potentially negatively impacting committee dialogue and deliberations as well as committee effectiveness. In addition, it was noted that for a particular year, the DENTAC representative was not present for any of the meetings and the Health Physician member was absent for ten of the eleven meetings. On the positive side, it was noted that the AFGE members attendance had improved from being absent from nine out of eleven meetings held in 2001 to being absent from only one out of nine meetings held in 2002.

MANAGEMENT OF HUMAN RESOURCES
Orientation, Training, and Education of Staff:
HR.4 – At one MTF, 48 out of 929 (94.8%) new staff failed to attend the required orientation program as documented within the Annual report On Staff Competence for the period January – December 2001. At another MTF, new employees are oriented, departmentally, by preceptors. One human resources file reviewed did not consistently provide evidence of documentation accurately describing the timeliness of orientation of employees. One employee was hired the end of June but the departmental orientation was not documented until mid-September.
At yet another MTF, one of 19 personnel files reviewed lacked documentation of an initial assessment of the staff member's ability to fulfill responsibilities included in the job description. The member underwent Newcomer Orientation on 9/01/01 and the first competency assessment recorded in the personnel file was dated April 2002.
HR.4.2 – At one MTF, the Annual Staff competency Report to the Governing Body for the period January – December 2001 documented that 90.2% had completed the required training.
HR.4.3 – At one MTF, the Staff Competency Report to the executive board for a particular year did not address levels of competency for non-medical staff credentialed patient caregivers except to globally refer to the nursing competency level. There was no differentiation of the competency spectrum for the various patient caregiver job categories/classifications so that an appreciation of the spectrum of staff competency could be ascertained. Finally, during the human resources interview it was learned that the organization had volunteer nursing personnel providing patient care, however, such staff was not included within the annual staff competency report to the executive board.
Assessing Competence:
HR.5 – At one MTF, out of 964 employee evaluations due within the last annual period, 957 were received on time (99.27%).
Credentialing and Privileging of Licensed Independent Practitioners:

MANAGEMENT OF INFORMATION
Information Management Planning:
IM.2.1 – At one MTF, in the imaging department, x-ray films are released after proper identification and authorization. The hospital keeps a log of the removed films; however, the hospital has neither a policy nor a process to insure the recovery of those films. It is only if asked for that the hospital would be aware of the missing films. The hospital developed a process to track and recover those films during the survey.

IM.5.1 – One organization has implemented a new form that is compliant according to the standards related to moderate sedation. During the tour of the ICU, an open record of a patient who received moderate sedation in interventional radiology was reviewed. Some elements of the pre sedation assessment were not performed because of the noncompliant template being used in that department. A process to ensure the usage of current forms in all areas should be implemented and enforced.
Two history and physicals were reviewed, one inpatient and one outpatient. The inpatient admission H&P had actually been completed in January, but January was scratched out and Feb. had been written over it so as to give the impression that the document had been produced in February.
The second case was a preoperative history and physical. This document had been produced as could best be determined by looking at a strike out in October 2001. This date was scratched out and the current date entered.
Patient-Specific Data and Information:
IM.7.2 – At one MTF, no procedure was formalized to define the location within the outpatient record where a patient's Advance Directive would be stored in cases where the patient requested the directive to become a part of his/her medical record.
In the open records reviewed in the substance abuse treatment program, documentation was not always present to demonstrate justification for not addressing some of the issues identified in the assessments.
At another MTF, in one of five moderate sedation medical records reviewed, it was noted that the record lacked documentation addressing the risk factor of moderate sedation in the medical history. This shortcoming in practice was identified eight months ago and both policy and practice have been revised to address this risk factor and to assure compliance with the new requirements.
IM.7.8 – At one MTF, the organization requires the medical staff members who make entries into the medical records to either print their signature or use a stamp. Open medical records reviewed did not consistently provide evidence of the stamp being used or name printed in order to assist the reader with identification of the author.
In all of the open medical records reviewed at another MTF, manual signatures on written documentation were also not always accompanied by a method of identifying the author.
IM.7.10 – At one MTF, legible entries were not consistently found in the open medical records, particularly in open medical records reviewed in the surgical clinic.

SURVEILLANCE, PREVENTION AND CONTROL OF INFECTION
Surveillance, Prevention and Control of Infection:
IC.4 – At one MTF, syringes used to inject medications were found removed from the sterile pack, in advance, in one office in Oral Surgery.
Some staff where not wearing OSHA compliant side shields in surgery, instead they were using their normal glasses as protective eyewear.
The policy regarding frequency of biological spore testing is daily. During the tour of the Dental clinic, the established frequency in that area for biological spore testing was weekly, which differed from the rest of the organization.
At another MTF, the use of CIDEX was prevalent throughout one organization. During the tour of the OB unit and the ultrasound department, two issues related to this disinfectant were found. The standard in the OB department was that CIDEX OPA would be tested for potency on a daily basis. The documentation presented during the tour did not provide evidence of compliance with the hospital policy. No evidence of documentation was found in the ultrasound department that potency testing was ever conducted.
The endoscopes in Endoscopy and the Internal Medicine clinic are washed in a central sterilization location. However, the endoscopes were sometimes stored in the open air and would be subject to contamination. It is recommended that these endoscopes be protected against such external contamination. As a result they would also be protected against possible damage.
Old reusable needles in glass tubes with cotton in each end were found in the plastic surgery clinic. These were removed during the survey.

At another MTF, it was noted that Infusion Pumps in various patient care units lacked an acceptable level of cleanliness. Further, there was no organization wide process in place to tell whether (and by whom) the pumps had been cleaned.
Also, in the Ophthalmology and ENT Clinics, it was noted that instruments with sharp protrusions did not consistently have tip protectors over the sharp protrusions to protect against perforation of the packages thus compromising sterility.
Also, at another MTF, in one instance, strategies to reduce the risk of nosocomial infections in patients appeared to fall below the usual standard of care; Laryngoscope blades used in the operating room were cleaned with Betadine detergent after use, neither disinfected nor sterilized, then returned to use on subsequent patients. Today's trend favors sterilization of those instruments that have intimate mucosal contact during use. A functioning Steris unit was available in the operating room. Terminal sterilization of the blades using the Steris system was recommended to the staff.
Finally at another MTF, there was no process in place to determine if the I.V. pumps had been cleaned and by whom.

MEDICAL STAFF

Credentialing:

MS.5.4.1 – At one MTF, the departments of the medical staff continue to laundry list privileges. There does not appear to be specific criteria for granting each of the requests. However, the medical staff policy supports proctoring to verify competence. The medical staff needs to develop criteria for granting each of the requests or move to core privileges.
MS.5.12.1 – One organization had practitioner specific information in all of the required measures of MS.8.1 and subsequent standards. This information, however, was not consolidated and aggregated so that it could be compared to peer performance as required by the standard. The organization needs to produce a comprehensive performance profile to allow the medical staff to compare each individual practitioner with the peer group and apply statistical analysis to detect variant practices.
MS.8.1 – At one organization, the quality profile for physicians does not display practitioner specific performance in some of the areas of required measurements. Namely: Medication use, e.g. Interventions into orders; Blood Prescribing, e.g. units transfused meeting transfusion criteria; Utilization review; Good department specific monitoring.
The data does exist for many of these issues, but they reside only at the function or departments level and there is little formal aggregate performance data for the above issues.
The hospital needs to pull together practitioner specific measurement and profiling and subject it to appropriate analysis for identification of undesirable trends and patterns, after comparing it with aggregate performance of the appropriate medical staff.
MS.8.3 – At one MTF, the medical staff peer review process, described in a memo, primarily addressed an older model of peer review activity consisting of medical records reviews, a model replaced by the September 1999 revision of this standard. The Divisions of Surgery and Medicine SOPs for peer review were entirely devoted to the older model. The risk management program, described in another memo, contained most but not all of the elements of today's approach to peer review. Taken altogether, the policies reviewed fell short of the six expected design elements bulleted in the intent of this standard. Missing design elements were: (1) definition of those circumstances requiring peer review and (2) an overall time frame in which peer review activities are to be conducted and the results reported. Recommended action was combination of elements of the various memos describing peer review activities into a single memo incorporating the design elements articulated in the intent of this standard.
At another MTF, the Healthcare Provider Peer Review Policy described an older model of peer review and did not address the expectations included in the late 1999 revision of this standard. None of the six expected design elements bulleted in the intent of the standard were included in the policy. However, another policy, entitled Risk Management Program did address five of six of the design elements expected by this standard (83%) compliance. Not addressed was the time frame in which peer review

activities were to be conducted, and the results reported. It was recommended that portions of the Risk Management Policy be relocated to an updated Peer Review Policy.

HOSPITALS-BEHAVIORAL-(EDIS)-2002
SUMMARY OF JCAHO SUPPLEMENTAL FINDINGS

ASSESSMENT

Initial Screening and Clinical Assessments:

PE.1.3 – In three out of seven records reviewed in EDIS at one MTF, and two out of five records reviewed at another MTF, there was no documentation of a nutritional screen being completed. Additionally, at the first MTF, in two records the assessment stated that a screen was completed but it was not present.

PE.1.8 – At one MTF, in three out of seven records, there was not an assessment of pain.

Additional Assessment of Children and Adolescents:

PE.1.18.3 – At one MTF, the records reviewed in EDIS did not include, in its assessment of growth and development, the child's nutritional development.

At another MTF, in only two out of seven records reviewed was the child's nutritional development addressed.

PE.1.18.4 – At one MTF, in only one of seven records reviewed, and two out of five records reviewed at another MTF, was there a clear and well-documented assessment of the child's play activities both individually and with others.

PE.1.18.5.6 – At one MTF, the physical health assessment did not address oral health and oral hygiene in all five records reviewed.

Assessment for Discharge – Planning Care Decisions and Reassessment:

PE.2 – At one MTF, the assessment in the EDIS program is comprehensive in nature and identifies a number of issues or needs for the child and the family. However, there is no process in place that identifies and prioritizes these needs in the records reviewed.

At another MTF, only in approximately half of the records reviewed was there a summary of the needs outlined.

CARE

Treatment Planning:

TX.1.7.3 – At one MTF, in one record reviewed in the EDIS program where the physician had made several recommendations, there was no documentation in the record to indicate that referral was made and any documentation as to the results of the referral.

TX.1.4.1 – At one MTF, the assessment process identifies a number of needs of the individual, in some cases there is no justification documented for deferring treatment.

EDUCATION:

Individual and Family Education and Responsibilities:

PF.3 – At one MTF, although there is attention to learning needs as part of the treatment process, a comprehensive assessment of learning needs is not documented. The surveyor recommends documentation of a comprehensive assessment of learning needs.

Education is provided as part of the treatment process in both group and individual sessions; however, the effectiveness is not documented clearly. Effectiveness of education provided can be inferred by documentation in the progress notes. The surveyor recommends implementation of a systematic approach to documentation of the effectiveness of interactive teaching. Both degree of understanding and needs for further follow-up teaching can be included as part of the system.

PF.3.1 – At one MTF, medication education is provided, but there is no system to ensure that each item required by the standard is documented consistently. The surveyor recommends implementation of a systematic approach to ensure consistent documentation of medication education.

MANAGEMENT OF HUMAN RESOURCES

Qualifications, Competencies, and Clinical Responsibilities:

HR.3.4 – At one MTF, while the EDIS program is gathering data regarding competence through performance evaluations and PI tools, they have not yet formally and systematically aggregated and analyzed the data to identify trends and patterns.

Competency Requirements for Special Populations:

HR.7 – At one MTF, there were no objective criteria to determine the competence of individuals working with children around growth and development.

HR.7 – At one MTF, There were no objective criteria that had been developed to measure staffs' knowledge of growth and development.

HR.7 – At three MTFs, staff responsible for children and adolescents demonstrate knowledge of growth and development through a test on age competency. However, there is no objective criteria developed (except for a test) that evaluates their skill or competence in working with children around growth and development

SURVEILLANCE, PREVENTION AND CONTROL OF INFECTION

Surveillance, Prevention and Control of Infection:

IC.2.2 – At one MTF, there was no documentation that the EDIS program was collecting data on infections with staff.

AMBULATORYS -2002
SUMMARY OF JCAHO TYPE ONE FINDINGS

LEADERSHIP:

Planning and Design of Services:

LD.1.10.3 – At one MTF, recently developed clinical practice guidelines were starting to be implemented but they have not started to measure their effectiveness.

MANAGEMENT OF INFORMATION:

Patient-Specific Data and Information:

IM.7.9 – One organization had limited evidence of a process or mechanism to track the location of any divergently located components of a medical record, for quick assembly and accessibility, when needed for use in patient care.

AMBULATORYS -BEHAVIORAL-(DRUG AND ALCOHOL)-2002
SUMMARY OF JCAHO TYPE ONE FINDINGS

ASSESSMENT

Initial Screening and Clinical Assessments:

PE.1.3 – At one MTF, of 6 open clinical records reviewed, 1 lacked evidence of a nutritional screen, and 2 lacked evidence of the criteria based nutritional screen for moderate or high nutritional risk, as part of the initial assessment. The organization recently instituted a criteria based nutritional screen.

PE.1.7 – At one MTF, a psychosocial assessment was completed on all patients reviewed; however, elements of the psychosocial lacked adequate information to allow for the development of a treatment

plan. Several elements were missing in the psychosocial assessment. This problem appears to be specific to the mental health clinic and not to the alcohol and drug program. Most elements of a psychosocial assessment were absent in 3 of 6 mental health cases reviewed. Specifically lack of an adequate description of the problem that brought the patient in, previous courses of treatment and there effectiveness, social interaction patterns, and extent of self injurious behavior by patients was absent in at least 50% of the cases reviewed in the mental health clinic.

CARE

Treatment Planning:

TX.1.6 – At one MTF, treatment, care, or service objectives were not measurable and expressed in functional or behavioral terms to assess incremental progress toward treatment goals. Measurability of any of the objectives was absent in 5 out of 7 alcohol, and drug, cases reviewed and was absent in 4 of 6 mental health cases reviewed.

Treatment, care, or service objectives did not reflect the individual's performance of reasonably anticipated outcomes within a specified time frame. Specifically, the objectives did not specify an estimated time frame that the patient would achieve the objectives within. This was a concern in the chart numbers identified above.

TX.1.9 – At one MTF, the individual's plan of care did not specify the criteria for discharge, transfer to another level of care of organization, or termination of treatment, care, or service. The criteria for discharge (including specific time frames) was only evident in 4 of 13 records reviewed. Discharge planning did not appear to be started early in treatment, care, or service. While some global discharge goals are addressed at the time of assessment, these lacked adequate specificity to help the patient understand what they would need to achieve in order to be discharged.

IMPROVING ORGANIZATION PERFORMANCE

Performance Improvement:

PI.5 – One organization had identified improvement projects to focus on, however, there was minimal evidence of ongoing or sustained performance. Transitions between unit clinical directors did not maintain measurement of previously prioritized processes for continuity and assurance of stability.

LEADERSHIP:

Role in Improving Performance:

LD.4.3 – At one MTF, the staff had not developed priorities to guide performance measurements nor assure processes and activities that were most important to treatment and care outcomes were continuously measured.

LD.4.4.4 – Interviews with staff at one MTF, revealed only minimal understanding of performance improvement, implementation of organizational methodology and application and use of statistical tools for analysis of data. In addition, sentinel events and the concept of reprioritization was minimally understood in terms of identification and reporting.

AMBULATORYS -2002
SUMMARY OF JCAHO SUPPLEMENTAL FINDINGS

ASSESSMENT OF PATIENTS

Initial assessment:

PE.1.4 – At one MTF, the organization has formulated a satisfactory pain assessment and management program and they are implementing appropriate tools for the assessment that will be present in all health care records. In addition, staff training has been performed. However, the full implementation of this program needs increased attention.

Structures Supporting the Assessment of Patients Function:
PE.4 – At one MTF, it was determined through discussions with staff and review of medical records that the organization had not consistently defined the scope of assessment to be performed by each discipline.

CARE OF PATIENTS
Medication Use:
TX.3.5 – At one pharmacy, it was observed that completed prescriptions of scheduled drugs waiting to be picked up by the patient were not properly secured.
At another MTF, the temperature range of the refrigerator in the main immunization clinic was set at 38-46 degrees Fahrenheit. However, the temperature limit for one of the vaccines, as prescribed by the manufacturer, was 41 degrees.
TX.3.9 – At one MTF, the emergency crash cart, in the endoscopy room of the surgery clinic, had one inoperable laryngoscope handle due to depleted and corroded batteries.

LEADERSHIP:
Integrating and Coordinating Services:
LD.3.1 – In reviewing certain minutes of one organization, it was impossible to ascertain final closure on certain agenda action items.
Improving Performance:
LD.4.1 – Leaders and staff at one MTF indicated that the organization had not incorporated principals that would assure data that was analyzed was valid, reliable, and adjusted for small sample sizes, into their knowledge of performance improvement. In addition, the organization had minimal understanding of process variation (both common and special cause), stability of processes, and utilization of prioritization when multiple potential performance improvement processes were being considered.

MANAGEMENT OF ENVIRONMENT OF CARE
Planning:
EC.1.5.1 – At one MTF, although the Plans For Improvement (PFI) was determined to be acceptable, additional Life Safety Code (LSC) findings had also been identified.
Part 4 – PFI of the Statement of Conditions (SOC) must be updated to include all supplemental recommendations identified in your official report. The updated PFI does not need to be sent to the Joint commission; however, it remains the MTFs responsibility to continue to maintain and update the PFI for review at future surveys
Implementation:
EC.2.1 – At one MTF, the portable O-2 tanks were not consistently monitored throughout the facility.
At another MTF, in 2 restrooms designed and designated for handicapped individuals which were located in patient care areas, there was no protective covering over the metal pipes and drains under the sinks to protect from injury to wheelchair bound visitors/patients.
EC.2.2 – The front door at one clinic is open 24 hours a day. However, it is not completely secured to prevent someone form entering unnoticed.

MANAGEMENT OF HUMAN RESOURCES
Competence Assessment:
HR.7.2.1 – At one MTF, the clinical privileges for one physician were not current with the scope of services currently provided by the organization.

MANAGEMENT OF INFORMATION:
Information Management Planning:
IM.2.1 – At one MTF, the review of processes involving security of medical records indicated individuals transitioning between bases at times hand carried their medical records unprotected against

loss, destruction and tampering. Data collected and reviewed regarding availability of medical records revealed approximately 100 to 400 medical records per month were either not available or missing greater than seven days.

Patient-Specific Data and Information:

IM.7.9 – At one MTF, Consultation appointments are made through an automated system by an outside scheduling organization and the date of the appointments transmitted to the patient and to the referring health care facility. Consultation reports are then usually forwarded to the facility after the appointment is kept. However, no system currently exists to identify when an appointment is NOT kept, therefore, patient care may be compromised since the referring physician may be under the impression that the patient has had a timely consultative evaluation or may be under the follow up care of the consultative physician.

Narrative summaries of hospitalizations are not always forwarded to the parent healthcare facility upon patient discharge. Although occasional notification is made that one of the patients may have been admitted to a hospital, this report is not routine or always informative. Again, patient care may be compromised because of lack of documentation of important patient care information.

AMBULATORYS -BEHAVIORAL-(DRUG AND ALCOHOL)-2002
SUMMARY OF JCAHO SUPPLEMENTAL FINDINGS

ASSESSMENT

Initial Screening and Clinical Assessments:

PE.1.8 – Of 6 open clinical records at on MTF, 1 record lacked evidence of an initial screening/assessment for pain.

PE.1.5.4 – At one MTF, an emotional and behavioral assessment did not include, when indicated, a mental status examination. The scope of the assessment was not sufficient to identify the individual's needs. The MSE was inadequate in 50% of the mental health cases reviewed. This did not appear to be a problem in the alcohol and drug cases reviewed.

PE.1.7.2 – At one MTF, the psychosocial assessment did not include information about leisure and recreation in 50% of the cases reviewed in the mental health clinic. The scope of the assessment was not sufficient to identify the individual's needs.

PE.1.7.7 – At one MTF, the psychosocial assessment did not include information about usual social, peer-group, and environment settings. The scope of the assessment was not sufficient to identify the individual's needs. This was absent or inadequate in 50% of the mental health clinic records reviewed. This did not appear to be problematic in the alcohol and drug program.

CARE

Treatment Planning:

TX.1.7.3 – At one MTF, concurrent treatment issues that are an integral part of meeting treatment, care, or service needs, were not reflected in the individual's plan of care in one of seven alcohol and drug cases reviewed. Specifically, in one case the clinician had referred the patient for a history and physical examination, but no documentation of the history and physical was evident in the patients record.

TX.1.8 – At one MTF, one clinical record lacked consistent updates on the patients' response to problems, specific goals and objectives and treatment services. The treatment plan updates did not consistently address the objectives/interventions but were an update on patient status.

LEADERSHIP:

Directing Services:

LD.2.1 – It was determined at one MTF that the behavioral health division was not as well integrated into the primary functions of the command such as the functions of understanding, directing, and implementing performance improvement.

MANAGEMENT OF ENVIRONMENT OF CARE

Planning:

EC.1.1.2 – The organizations' policy does not permit smoking within 50ft of the Alcohol & Substance Abuse Program building. Exiting the building, the surveyor and surveyor escort came upon individuals smoking within 15-20 ft of the program doors. A staff person came out and requested individuals to smoke in the designated area

MANAGEMENT OF INFORMATION:

Information Management Planning:

IM.1 – At one MTF, internal and external information management procedures are usually appropriate for the organization size and complexity. However, the organization was not able to generate open and closed records list to assist in the survey process or in case management functions within the mental health or alcohol and drug programs.